IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 6605**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**BEDE LEVI DAVIES**
Date of birth:	**2 NOVEMBER 1988**
Date of death:	**30 DECEMBER 2017**
Cause of death:	**I (a) ACUTE BRONCHOPNEUMONIA IN A MAN WITH CARDIOMEGALY** **CONTRIBUTING FACTORS** **CLASS III OBESITY**
Place of death:	**PORT PHILLIP PRISON, 280 PALMERS ROAD, TRUGANINA, VICTORIA, 3029**

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I, PHILLIP BYRNE, Coroner having investigated the death of BEDE LEVI DAVIES
without holding an inquest:
find that the identity of the deceased was BEDE LEVI DAVIES
born on 2 November 1988
and the death occurred on 30 December 2017
at the Port Phillip Prison, 280 Palmers Road, Truganina, Victoria, 3029

from:

1 (a) ACUTE BRONCHOPNEUMONIA IN A MAN WITH CARDIOMEGALY

CONTRIBUTING FACTORS

CLASS III OBESITY

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

Background

1. Bede Davies, an aboriginal man, 29 years of age at the time of his death, was an inmate at Port Phillip Prison in Truganina.

Circumstances of the death

2. On 30 December 2017 at approximately 5.20pm, an inmate entered Mr Davies cell who was in bed. The inmate shook Mr Davies however could not illicit a response. The inmate indicated Mr Davies felt cold. The inmate presumably concluding Mr Davies was asleep, went to get his dinner, after which he returned to his cell, and then to Mr Davies cell. Sensing something was not right, the inmate pressed the buzzer to Mr Davies cell which has alerted prison staff.

3. Prison staff who attended Mr Davies cell found him unresponsive and moved him to the common area where they commenced cardio pulmonary resuscitation. Despite their efforts Mr Davies could not be revived and was formally declared deceased by ambulance officers at approximately 6.11pm.

Post-mortem examination and report

4. Mr Davies's death was reported to the coroner. Having considered the circumstances and having conferred with a forensic pathologist, and being advised the Senior Next of Kin consented to autopsy, I directed an autopsy and ancillary tests be conducted.

5. Subsequently Forensic Pathologist Dr Heinrich Bouwer provided an Autopsy Report advising Mr. Davies died due to

(a) Acute Bronchopneumonia in a man with cardiomegaly

Contributing Factors

Class III obesity

Dr Bouwer commented:

> *"At autopsy, was significant natural disease affecting the cardiorespiratory systems. The heart was significantly enlarged, floppy and dilated. Histological examination showed pericellular fibrosis, but no evidence of specific cardiomyopathy, valve pathology, myocarditis or infarction. There was no significant coronary artery atherosclerosis. The cause of the cardiac enlargement is not known, but could be complication of obesity, stimulating drug use or hypertension. In addition there was bilateral acute bronchopneumonia".*

Further investigation

6. As Mr Davies was in custody at the time of his death, following established protocols, both the Justice Assurance and Review Office (JARO) and Justice Health respectively reviewed Mr Davies's correctional management and delivery of health care while in custody.

7. JARO in its report dated 27 September 2018 concluded:

> *"Port Phillip's response to Mr Davies death was appropriate and that Port Phillip staff should be commended in their efforts to preserve Mr Davies life"*

8. Justice Health in its report dated 20 February 2018 found:

"Based on a file review of Mr Davies medical record there is nothing to suggest that the healthcare provided to Mr Davies was not in accordance with the Justice Health Quality Framework 2014".

9. Having examined both reports provided to the Court, I am satisfied Mr Davies' correctional management was in accordance with the standards prescribed by Corrections Victoria. I am further satisfied that the healthcare provided to Mr Davies while in custody was in accordance with the Justice Health Quality Framework 2014.

10. Following a relatively recent amendment to the Coroners Act 2008, I am able to make a formal finding without recourse to the forensic judicial process (inquest) in circumstances where the cause of death of a person in custody is due to natural cause. I am entirely satisfied Mr Davies' death was due to natural causes. I finalise my coronial investigation by way of this Finding without Inquest.

Finding

11. I formally find Bede Levi Davies died at Port Phillip Prison on 30 December 2017 due to acute bronchopneumonia in a man with cardiomegaly. I am satisfied his untimely death was due to natural causes.

12. Pursuant to section 73 (1) (B) of the *Coroners Act 2008* (Vic), I direct that this finding be published on the Coroners Court of Victoria website.

13. I direct that a copy of this finding be provided to the following:

Mr Glen and Mrs Derinda Davies, Senior Next of Kin;

Ms Michelle Gavin, Director, Justice Assurance and Review Office;

Mr Scott Swanwick, Justice Health;

Ms Ingrid Nunnink, Marsh & Maher Richmond Bennison Lawyers for G4S Custodial Services Pty Ltd:

Ms Melanie Kyezor, Clinical Risk Manager, St Vincent's Health; and

Senior Constable Sophie Templeton, Victoria Police Reporting Officer.

Signature:

PHILLIP BYRNE
CORONER
Date: 7 December 2018